STATE OF MICHIGAN

COURT OF APPEALS

LOLINDA RANDOLPH, Personal Representative of the Estate of BRYAN RANDOLPH, Plaintiff-Appellee,	UNPUBLISHED July 22, 2010
v HENRY FORD HOSPITAL, HENRY FORD SYSTEM, INC., DR. SCOTT E. LANGENBERG, and MICHIGAN PEDIATRIC SURGICAL ASSOCIATES, P.C., Defendants-Appellants.	No. 285103 Wayne Circuit Court LC No. 05-533887-NH

Before: SAAD, C.J., and O'CONNELL, and ZAHRA, JJ.

PER CURIAM.

In this medical malpractice action, defendants appeal as of right from a judgment for plaintiff, entered following a jury trial.[1] We reverse.

I. Background

This case arises from the unfortunate death of infant Bryan Randolph. Pediatric surgeon Dr. Scott Langenberg was consulted shortly after Bryan's birth on March 22, 2001, due to apparent intestinal problems. He suspected that Bryan might have Hirschsprung's disease.[2] Test results were inconclusive and, after sufficient improvement, Bryan was released from the hospital without a diagnosis. Within a few days, Bryan returned to the hospital because he was unable to tolerate his feedings. Another test for Hirschsprung's disease was performed and was also inconclusive. Bryan improved sufficiently to be released on April 5, 2001, again without a

[1] The parties stipulated at trial that if Dr. Langenberg was liable, the remaining defendants were liable as well.

[2] Hirschsprung's disease occurs when there is a lack of ganglion nerve cells in all or part of the colon that causes it to not function normally by not allowing feces to pass out of the body. Thus, constipation is a hallmark of the disease. It is treated by surgically removing the tissue that lacks ganglion cells.

diagnosis. Over the next month, Bryan was relatively healthy. He fed well and gained weight, but experienced intermittent, on-going bouts of constipation, some of which were relieved only with the assistance of a suppository.

Bryan had his first follow-up office visit with Dr. Langenberg on April 24, 2001. Dr. Langenberg's records reflect a reported history of Bryan feeding and stooling well. No bowel movement problems were conveyed. Dr. Langenberg was less worried about the possibility of Hirschsprung's disease because it appeared that Bryan's constipation was resolved. He stated that children with Hirschsprung's disease are nutritionally behind and do not look like they are thriving, the opposite of Bryan's condition at that time. He told Bryan's parents that if the issue redeveloped, he wanted to do a full thickness biopsy to determine definitively if Bryan had the disease.

In the few days before May 8, 2001, Bryan was feeding well, but could not pass hard stool even with the assistance of a suppository. He only passed liquid stool and there was testimony that his lips would turn bluish-purple and that he would grunt when attempting unsuccessfully to pass stool. He was also very sleepy and lethargic. On May 8, 2001, Bryan's parents called Dr. Langenberg, who saw Bryan in his office around noon. Because Dr. Langenberg still suspected that Bryan might have Hirschsprung's disease, he was concerned that Bryan may have developed a serious complication of it, Hirschsprung's enterocolitis.[3] Other than symptoms related to the constipation (lethargy, mildly distended abdomen, hard stool in his rectum with liquid stool around it), Bryan appeared healthy to Dr. Langenberg. Dr. Langenberg ruled out Hirschsprung's enterocolitis because there was no explosion of stool upon rectal examination and Bryan was only mildly distended in the abdomen. Dr. Langenberg testified that had Bryan been fully impacted and at risk for Hirschsprung's enterocolitis, his abdomen would have been markedly distended. Since Bryan continued to have bowel issues, Dr. Langenberg scheduled him for a definitive test for Hirschsprung's disease the following week. In the meantime, he recommended that Bryan be given an enema and laxatives to treat the constipation.

Throughout the remainder of the day, Bryan's parents noticed that Bryan appeared to be getting worse. His feedings trailed off, the enema did not relieve his constipation, and his urine was dark. He also continued to be very lethargic, he was grunting and straining constantly, and his eyes began "rolling around in his head" and crossing. Later that evening, Bryan's mother took Bryan to the emergency room where Dr. Jeremiah Weekes examined him at 8:48 p.m. Bryan's vital signs were normal, but he appeared mildly dehydrated and pale. At 8:55 p.m., Bryan stopped breathing. Resuscitation efforts were unsuccessful and Bryan was pronounced deceased at 9:45 p.m. Dr. Weekes concluded that the cause of death was cardiopulmonary arrest secondary to dehydration, unless upon autopsy, sepsis was found. The medical examiner was

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[3] Hirschsprung's enterocolitis can lead to death very quickly. It occurs when the body cannot rid itself of bacteria in stool due to a functional blockage or fecal obstruction. Bacteria multiplies and enters the bloodstream causing sepsis and severe illness. Symptoms of Hirschsprung's enterocolitis are fever, rapid breathing, sudden onset of poor feeding, lethargy, a very tense balloon-like distended abdomen, and explosive watery stool upon rectal examination.

unable to detect the cause of death, ruling out both dehydration and Hirschsprung's disease. Bryan's official cause of death was listed as unknown.

II. Analysis

Defendants argue that the trial court erred in denying their motions for a directed verdict and judgment notwithstanding the verdict ("JNOV"). They argue that plaintiff failed to establish that Dr. Langenberg breached the standard of care or that any alleged breach was the proximate cause of the Bryan's death.

A. Standards of Review

We review de novo a trial court's decision on a motion for a directed verdict. *Silberstein v Pro-Golf of America, Inc*, 278 Mich App 446, 455; 750 NW2d 615 (2008). We review all the evidence presented up to the time of the motion to determine whether a question of fact existed. *Id*. The evidence and any reasonable inferences that arise from the evidence are viewed in the light most favorable to the nonmoving party. *Elezovic v Ford Motor Co*, 472 Mich 408, 418; 697 NW2d 851 (2005). In other words, all conflicts in the evidence are resolved in favor of the nonmoving party. *Ververis v Hartfield Lanes*, 271 Mich App 61, 63-64; 718 NW2d 382 (2006). A directed verdict is appropriate only when no factual question exists upon which reasonable minds could differ. *Smith v Foerster-Bolser Constr, Inc*, 269 Mich App 424, 427-428; 711 NW2d 421 (2006).

We also review de novo a trial court's decision on a motion for JNOV. *Sniecinski v Blue Cross & Blue Shield of Michigan*, 469 Mich 124, 131; 666 NW2d 186 (2003). This Court must view the evidence and all legitimate inferences that arise from it in the light most favorable to the nonmoving party to determine whether a question of fact existed. *Livonia Bldg Materials Co v Harrison Constr Co*, 276 Mich App 514, 517-518; 742 NW2d 140 (2007). If reasonable jurors could have honestly reached different conclusions, the jury's verdict must stand. *Zantel Marketing Agency v Whitesell Corp*, 265 Mich App 559, 568; 696 NW2d 735 (2005).

B. Breach

To establish a claim of medical malpractice, a plaintiff must show: (1) the appropriate standard of care governing the defendant's conduct at the time of the purported negligence; (2) that the defendant breached that standard of care; (3) that the plaintiff was injured; and (4) that the plaintiff's injuries were the proximate result of the defendant's breach of the standard of care. MCL 600.2912a; *Craig v Oakwood Hosp*, 471 Mich 67, 86; 684 NW2d 296 (2004). Expert testimony is required to establish the applicable standard of care and to demonstrate that the defendant breached that standard. *Gonzalez v St John Hosp & Medical Ctr (On Reconsideration)*, 275 Mich App 290, 294; 739 NW2d 392 (2007). MRE 703 requires that the facts on which an expert bases an opinion or inference be in evidence. Thus, an expert's opinion is objectionable when it is based on assumptions that are consistent with but not deducible from the established facts because it constitutes impermissible conjecture. *Wiley v Henry Ford Cottage Hosp*, 257 Mich App 488, 498; 668 NW2d 402 (2003).

Defendants argue that the trial court erred in denying their motions for directed verdict and JNOV because plaintiff failed to establish through expert testimony that Dr. Langenberg

breached the standard of care by failing to hospitalize Bryan. Plaintiff's theory of causation at trial was essentially that, on May 8, 2001, Bryan was suffering from an unconfirmed illness, purportedly Hirschsprung's disease or even Hirschsprung's enterocolitis, and that given Bryan's medical history and presentation, Dr. Langenberg failed to hospitalize him. Further, that had Bryan been hospitalized, he would have been hydrated and disimpacted, and Bryan would have survived.

Essentially, Dr. Palder, plaintiff's expert witness, offered three reasons for why Bryan should have been hospitalized. The first reason was for hydration to treat Bryan's moderate dehydration that he allegedly displayed at the office visit. The second reason Dr. Palder gave for hospitalizing Bryan was to have his bowels disimpacted because he believed that the hard stool in Bryan's rectum was impacted. The last reason Dr. Palder gave for hospitalizing Bryan was to determine the cause of Bryan's bowel problems.

In regard to dehydration, we agree with defendants that there was no record evidence at the time of Bryan's May 8, 2001 visit to Dr. Langenberg that supported Dr. Palder's opinion that Bryan was moderately dehydrated. Dr. Palder even conceded this point at trial. Bryan had no recent history of vomiting or diarrhea. While Bryan had liquid stools for several days, Dr. Palder admitted that he did not know how much fluid was expelled. In addition, Bryan's test results from blood drawn just after the visit were inconsistent with dehydration. Furthermore, plaintiff's other expert, Dr. Sperry, testified that while he suspected that Bryan was dehydrated in Dr. Langenberg's office, he could not state with a reasonable degree of medical certainty that Bryan was dehydrated based on the information before him.

The only remaining basis for Dr. Palder's opinion was an inference that stemmed from Bryan's dehydrated state in the emergency room. Dr. Palder opined that it was reasonable to believe that Bryan was dehydrated in Dr. Langenberg's office based on the short period of time between the office visit and Bryan's examination in the emergency room. He did not think that had Bryan's dehydration begun after the office visit, it would have progressed to the point of causing arrest approximately six hours later. While it may be reasonable to infer with the benefit of hindsight that Bryan was in fact dehydrated at the time of May 8, 2001 visit, this evidence cannot support an inference that Bryan exhibited signs of dehydration at the time of the visit. In other words, because there were no objective signs of dehydration during the office visit, Dr. Langenberg could not have reasonably known that Bryan was dehydrated. Accordingly, Dr. Palder's opinion that Dr. Langenberg should have hospitalized Bryan for hydration is unsupported by the record evidence.[4]

The second reason Dr. Palder gave for hospitalizing Bryan was to have his bowels disimpacted. Dr. Palder testified that the hard stool in Bryan's rectum was impacted. However, Dr. Palder later testified that his conclusion in regard to impaction was based solely on the reference to impaction in the history section of Dr. Langenberg's medical note for the May 8 2001, office visit. Moreover, Dr. Langenberg expressly testified that while his exams found hard

[4] Notably, there was no evidence presented that the standard of care required that Dr. Langenberg anticipate that Bryan would become dehydrated after the visit.

stool balls in the rectal vault, there was not a complete blockage, i.e., impaction, at the May 8, 2001 visit. He also testified that if there were a complete blockage Bryan would have a markedly distended abdomen and that he would have hospitalized him. Despite plaintiff counsel's vigorous cross-examination of Dr. Langenberg on the subject, Dr. Langenberg never agreed there was an impaction at the visit. Further, Dr. Palder agreed that if Dr. Langenberg testified that he found no impaction upon examination, there was no need for Bryan to be disimpacted at the hospital. Accordingly, Dr. Palder's opinion that Dr. Langenberg should have hospitalized Bryan to remove an impaction is likewise unsupported by the record evidence.

The last reason Dr. Palder gave for hospitalizing Bryan was to determine the cause of Bryan's bowel problems. Dr. Palder testified that based on Bryan's medical history and clinical presentation, the standard of care required hospitalization because Dr. Langenberg had before him an infant who had intermittent, yet continuing, bowel problems whose cause had not been diagnosed, but for which Dr. Langenberg highly suspected Hirschsprung's disease as the cause. However, this theory is based on Dr. Palder's determinations that Bryan was "moderately dehydrated" and "impacted" at the May 8, 2001 office visit. As discussed above, there is no basis to support these conclusions.

We reject plaintiff's claim on appeal that "Dr. Langenburg [sic] should have hospitalized the child apart from any finding of dehydration at the time of the visit." Dr. Palder's affidavit of merit maintained that Dr. Langenberg violated the standard of care by "failing to adequately evaluate and treat Bryan Randolph's dehydration." In the joint pretrial order, the parties agreed and the trial court acknowledged "issues of facts remaining to be litigated" that included "[t]he circumstances of Bryan Randolph's presentation to Dr. Langenburg's [sic] clinic on May 8, 2001 (including history, presenting signs and symptoms, laboratory testing and whether Bryan Randolph was dehydrated)." Further, Dr. Palder testified more than once that he believed that Bryan was "moderately dehydrated" at the time he visited Dr. Langenberg's office on May 8, 2001.

Here, the only testimony in which Dr. Palder stated that the standard of care required Dr. Langenberg to hospitalize Bryan absent any indication of dehydration was on re-direct examination. After Dr. Palder had conceded there was no evidence that Bryan was moderately dehydrated at the visit, plaintiff counsel elicited testimony that the standard of care required Bryan to be hospitalized based on a May 8, 2001 note from Dr. Langenberg to pediatrician Dr. Jeannette Marchand-Mateyak that chronicled the visit. The note did not mention dehydration, but did mention that "*lately* the patient has been having liquid stool running around a rectal impaction." (Emphasis added). This is a medical history note for the benefit of Bryan's pediatrician. This statement is not a description of Bryan's condition at the May 8, 2001 visit. Significantly, the note further states "*on examination* . . . there is hard stool in the vault." (Emphasis added). As previously mentioned, Dr. Langenberg expressly testified that while his exams found hard stool balls in the rectal vault, there was not a complete blockage, i.e., impaction, at the May 8, 2001 visit. Despite "rectal impaction" only being mentioned as part of Bryan's reported history given to Dr Langenberg, Dr. Palder agreed with plaintiff counsel that the note indicated "we *know* that he had liquid stool running around and [sic] rectal impaction." (Emphasis added). The note, however, did not provide a basis to draw this conclusion. Indeed, Dr. Palder had previously testified that the note "doesn't say, necessarily, yeah, impaction or no impaction." Given that Dr. Palder agreed that the note did not provide evidence of rectal

impaction, Dr. Palder could not have reasonably concluded that the standard of care required Bryan to be hospitalized based on the May 8, 2001 medical history. Thus, we conclude that the trial court erred in denying defendants motion for directed verdict and JNOV.

Reversed.

/s/ Henry William Saad
/s/ Peter D. O'Connell
/s/ Brian K. Zahra